



DEPARTMENT OF ECONOMIC SECURITY

Your Partner For A Stronger Arizona

PROVIDER MANUAL

DIVISION OF DEVELOPMENTAL DISABILITIES

4/26/2013

Introduction to Provider Manual

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Introduction to Provider Manual

The information contained is current as of the date it was published, and may be modified by the Division of Developmental Disabilities (Division or DDD) at any time. This manual was designed so that updates and changes can be implemented efficiently. The dates in the upper left hand corner designate when a section has been updated.

Providers are obligated to adhere to and comply with all of the terms and conditions of the contract they have with the Division, including the requirements described in this manual in addition to all federal and state regulations governing the Arizona Long Term Care System (ALTCS) program. While this manual contains basic information about the Arizona Health Care Cost Containment System (AHCCCS), providers are required to fully understand and apply AHCCCS requirements when administering covered services.

In the event of a conflict or inconsistency between this manual and federal or state regulatory requirement, federal or state regulatory requirements will take precedence. Additionally, in the event of a conflict or inconsistency between your contract and this Provider Manual, the provisions of your contract will take precedence.

CHAPTER 1 - INTRODUCTION TO THE DIVISION OF DEVELOPMENTAL DISABILITIES

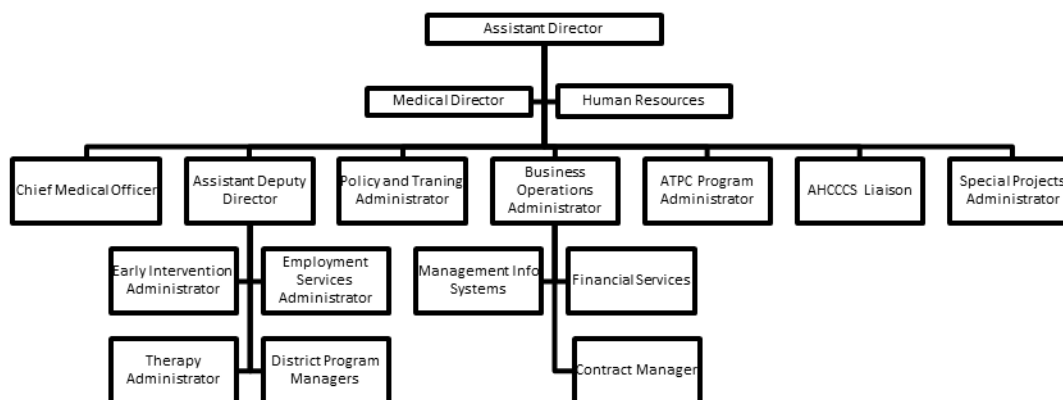
INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [A.R.S. § 36-554\(A\) \(10\)](#)

Program Description

The Division of Developmental Disabilities within the Arizona Department of Economic Security (Department or ADES) provides services and programs to people with developmental disabilities and their families. The Division believes that people can best be supported in integrated community settings and the majority of the Division's programs and services are tailored to meet the individual needs of people with developmental disabilities and their families at home and in community-based settings.

The Division coordinates services and resources through central administrative offices, five district offices and local offices located in communities throughout Arizona. While some services are delivered directly by the State, almost all services and supports are delivered through a network of individual and agency providers throughout Arizona.



The Division contracts with Acute Care Health Plans that together provide medical care to ALTCS members with developmental disabilities residing in every Arizona County. The health plans are responsible for assigning or allowing each person who is enrolled the choice of a primary care provider. The current contracted health plans are Arizona Physicians Independent Physician Association, Mercy Care Plan, and Care 1st Health Plan Arizona.

American Indian Health Program (AIHP) is selected as the primary provider by many Native American members. When AIHP makes a referral for service(s) outside their facilities, the Division is responsible for these services on a fee-for-service basis.

Division Credo and Value Statement

The Division, in partnership with consumers with developmental disabilities, their families, advocates, community members and service providers, will develop, enhance, and support environments which will enable consumers with developmental disabilities to achieve and maintain physical well-being, personal and professional satisfaction, and participation as family and community members, and safety from abuse and exploitation.

The following value statements reflect the Division's philosophy:

We value:

- A. The development and fostering of personal relationships with family and friends.
- B. Consumer and family initiative in making choices and expressing preferences.
- C. Equal access to quality services and supports for all individuals.
- D. Consumers as welcomed, participating, and contributing members in all aspects of family and community life.
- E. The rights of all individuals and the preservation of their worth, value and dignity.
- F. Healthy relationships with people.
- G. Individual and family priorities and choices.
- H. Equal access to quality services and supports for all individuals and families.
- I. Partnerships and ongoing communication with individuals, family members, advocates, providers, and community members.
- J. Developmental approaches – changing conditions that affect people rather than changing people who are affected by conditions.

- K. Individual freedom from abuse, neglect and exploitation with a balance between the right to make choices and experience life and individual safety.
- L. A diverse workforce that is motivated, skilled and knowledgeable of and uses the most effective practices known.
- M. An environment rich in diversity in which each person is respected and has the opportunity to reach their optimal potential.
- N. An individual's right to choose to participate in and contribute to all aspects of home and community life.
- O. A system of services and supports which are:
 - 1. Responsive – timely and flexible responses to internal and external customers
 - 2. Strength based – recognizing people's strengths, promoting self-reliance, enhancing confidence and building on community assets
 - 3. Effective – ongoing identification of effective methods and practices and incorporation of those practices into operations
 - 4. Accountable to our customers and to the taxpayers.

Therefore:

- A. Programs and services will be offered in a manner which supports and enhances independence, self-esteem, mutual respect, value and dignity.
- B. Within available resources, programs and services will be offered to support consumer and family preferences and choices regarding opportunities for consumers to learn/gain, exercise personal and professional competence and shape personal futures.
- C. Opportunities, programs and services will be designed and developed in partnership with consumers, families, advocates, community members and service providers.

- D. Families and friends will be recognized as the primary providers of support, nurturing, and training, and as capable of determining their own needs.
- E. Programs and services will be provided through a comprehensive, home and community-based system which recognizes and supports cultural diversity.
- F. Programs and services will be designed and offered to promote optimum physical, mental and emotional well-being.
- G. The Division will work cooperatively with community and business leaders to develop information and access to community programs and supports for consumers. It will participate in community education programs regarding developmental disabilities.
- H. Programs and services will be offered in a manner which exhibits effective, efficient and appropriate management and public accountability.
- I. Decisions, actions, and program development will be guided by the Division philosophy, values, and imperatives.

Behavioral Health Services Network

The majority of behavioral health services are provided through the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS). The ADHS/DBHS receives a capitation for these services that is appropriated directly by the Arizona Legislature. The Division administers the service delivery through an Interagency Service Agreement (ISA) with the ADHS/DBHS. Ultimately, the Division is responsible for ensuring that the delivery of behavioral health services is meeting the needs of the members being served.

In addition to behavioral health services provided through ADHS/DBHS, the Division provides other home and community based for members using behavioral health services. These services are part of and contained in the Home and Community Based Services (HCBS) information.

Home and Community Based Services (HCBS) Network

HCBS are supports to promote independence and inclusion within the community for eligible members with developmental disabilities and their families, in the least restrictive home and community-based settings. These services include, but are not limited to: in-home services (e.g., attendant care, habilitation, respite); habilitative therapies; day programs; employment programs; and residential services.

The Division contracts with over 600 Qualified Vendors and 1,800 Independent Providers to provide this array of home and community-based services.

CHAPTER 2 - PROVIDER RESPONSIBILITIES AND EXPECTATIONS

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [Service Specifications](#); [DDD Rules](#); [ALTCS Rules](#)

All providers must have a valid AHCCCS identification number. If applicable, the provider must also have a National Provider Identifier (NPI), proper licensure according to state and federal regulations, and documentation indicating compliance with local fire and sanitation codes and regulations.

All providers must ensure each member's privacy is protected, in accordance with the privacy requirements in 45 CFR parts 160 and 164.

Qualified Vendors and Independent Providers will:

- A. Provide services in a manner that supports and enhances the member's independence, self-esteem, mutual respect, value and dignity.
- B. Actively participate in the member's Planning Team meeting at the date, time, and location determined by the Division.
- C. Meet with the member and, if applicable, the primary caregiver prior to initiating service and obtain necessary information.
- D. Administer first aid and appropriate attention to injury or illness.
- E. Report incidents in accordance with the Division's Policy Manual.
- F. Submit progress reports and teaching strategies as required, including measurable data to validate the effectiveness of the service, to aid the Support Coordinator in assessing the continued need for the service.
- G. Notify the Support Coordinator to request a Planning Team meeting whenever there is a significant change in the member's status.
- H. Complete other assignments as determined by the Planning Team.
- I. Provide services as authorized by the Division.

CHAPTER 3 - PROVIDER SERVICE DEPARTMENTS

INITIAL IMPLEMENTATION DATE: March 29, 2013

The Division offers a variety of assistance for its providers. Providers may contact the following Division offices for assistance as needed.

	Contact Number	Assistance Offered
Billing/Claims: Long Term Care & Early Intervention	602-542-6874	<ul style="list-style-type: none">• Waivers• Submitting claims• Assistance with pended or denied claims
Acute Care	602-364-0529	
Claim Disputes	602-771-8163	<ul style="list-style-type: none">• Questions
Contract Management	602-542-6874	<ul style="list-style-type: none">• Requesting a Qualified Vendor Application and Independent Provider Application• Adding services• Expanding to other areas of the state
Customer Service	602-542-6874	<ul style="list-style-type: none">• General questions
Health Care Services	602-771-8080	<ul style="list-style-type: none">• Acute care services• Prior authorization (AIHP)
Grievances/Complaints	602-542-0419	
Acute Care Health Plans: APIPA	1-800-445-1638	Medical providers providing services for members enrolled with an acute care contractor should contact the appropriate Health Plan
Care1st	602-778-1800	
Mercy Care	1-800-624-3879	

CHAPTER 4 – COVERED AND NON-COVERED SERVICES

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [HCBS Service Descriptions](#); [Acute Service Descriptions](#)

COVERED SERVICES

The Division follows AHCCCS guidelines pertaining to the services that are covered under the ALTCS program as set forth in the AHCCCS Medical Policy Manual (AMPM). You are encouraged to view the AMPM on the AHCCCS website for further information about covered services.

Examples of covered services for members under the age of 21 years include, but are not limited to:

- Emergency room services
- Dental
- Vision
- Doctor's office visits
- Urgent care
- Transplants
- Family planning services
- Medications
- Behavioral health services
- Therapies
- Respite
- Habilitation
- Attendant care services

Examples of covered services for members age 21 years and over include, but are not limited to:

- Emergency room services
- Doctor's office visits
- Urgent care
- Family planning services
- Medications
- Behavioral health services
- Respite
- Habilitation
- Attendant care services
- Residential

NON-COVERED SERVICES

Examples of non-covered services for members age 21 years and over:

- Most dental care
- Insulin pumps
- Percussive vest
- Visits to a podiatrist
- Certain transplants

Examples of non-covered services for members of all ages:

- Vehicle modification
- Vehicle lift
- Day care
- Additions to homes
- Pill crusher
- Service animal
- Life coach
- Home repairs
- Rent

CHAPTER 5 – EMERGENCY ROOM UTILIZATION

INITIAL IMPLEMENTATION DATE: March 29, 2013

Emergency services are covered for all Division ALTCS members. The Division views the member's Primary Care Provider (PCP) as the gatekeeper for medical services. Given this, non-emergency services should be addressed by the PCP. Urgent care centers are also available, as appropriate.

The Division encourages its providers to educate members on appropriate utilization of emergency room and urgent care centers.

CHAPTER 6 - EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT (EPSDT)

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [AHCCCS Manual](#)

Members age 21 years and under who are eligible for AHCCCS are also eligible for Early and Periodic Screening, Diagnosis and Treatment (EPSDT). EPSDT offers comprehensive health care services through primary prevention, early intervention, diagnosis and medically necessary treatment to correct or ameliorate defects and physical or mental illness discovered by screenings. This includes required health, developmental, and behavioral health screenings.

Services include, but are not limited to, screening for hypertension, elevated cholesterol, colon cancer, sexually-transmitted diseases, tuberculosis, HIV/AIDS, breast cancer, cervical cancer, and prostate cancer. Nutritional assessment and treatment are covered when medically necessary to meet the nutritional needs of members who may have a chronic debilitating disease. Physical examinations, diagnostic work-ups and medically necessary immunizations are also covered as specified in Arizona Administrative Code, R9-22-205. EPSDT providers must document immunizations into Arizona State Immunization Information System (ASIIS) and enroll annually in the Vaccine for Children Program.

CHAPTER 7 - DENTAL

INITIAL IMPLEMENTATION DATE: March 29, 2013

Members age 20 years and younger are covered for both preventative and restorative dental services. These services include, but are not limited to:

- Examinations
- Cleanings
- Extractions
- Sealants
- X-rays
- Amalgam or resin restorations

For members age 21 years and over, dental services are only covered when related to the treatment of a medical condition, covered transplants, and preparation for certain radiation treatments. Examples of medical conditions that warrant dental services are infection or the fracture of the jaw. Adult members have access to limited emergency dental services. These services include, but are not limited to:

- Treatment of facial trauma
- Treatment of fractures
- X-rays
- Emergency examinations

CHAPTER 8 – FAMILY PLANNING

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [AHCCCS](#) – Medical Policy Manual

Family planning services are covered for members to delay or prevent pregnancy. Covered family planning services include medical, surgical, and pharmacological and laboratory services, as well as contraceptive devices, information and counseling services which allow members to make informed decisions regarding family planning methods.

Member requests for tubal ligation or vasectomy must receive prior authorization from the Division's Medical Director.

Elective sterilization by hysterectomy will not be authorized in accordance with the AMPM. Elective hysterectomy due to medical necessity requires prior authorization by the Division's Medical Director.

CHAPTER 9 - PCP ASSIGNMENTS

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [Mercy Care Plan](#); [Care 1st](#); [Arizona Physicians, IPA](#)

The Division contracts with three Acute Care Health Plans to deliver acute health services for its members. The acute care health plan is responsible for assigning a PCP to enrolled members. Please refer to the health plan's website for information about the PCP assignment process.

Members who are of Native American descent may choose to receive acute care services through the American Indian Health Program (AIHP). The Division operates the acute care service delivery system for these members. When a member elects AIHP, the Division's Support Coordinator works with the member to select a PCP that provides geographically convenient and culturally appropriate services.

All Division members can change their PCP at any time. Members enrolled with an acute care contractor should contact the Division Liaison or the health plan's Member Services Unit to execute a PCP change.

CHAPTER 10 - REFERRALS TO SPECIALISTS

INITIAL IMPLEMENTATION DATE: March 29, 2013

For DDD American Indian Health Program (AIHP) members, providers need to receive a prior authorization in order to see a specialist; however, they do not necessarily need to receive a referral from their PCP. A prescription is required for any medical service, including but not limited to, durable medical equipment, nutrition, and prescription medications.

The Division's Health Plans vary in their policy and procedures regarding referrals to a specialist. Providers are expected to follow these policies and procedures.

For AHCCCS eligible members, behavioral health services are available through the Regional Behavioral Health Authority (RBHA). No referral is required to initiate these services. The Division expects providers to assist members in initiating these services. The provider must notify the Support Coordinator when assistance to initiate these services has been provided.

CHAPTER 11 – ALTCS GRIEVANCES, CLAIM DISPUTES, AND APPEALS

INITIAL IMPLEMENTATION DATE: March 29, 2013

Grievances

A grievance is an expression of dissatisfaction. Grievances may pertain to the quality of care or services provided or dissatisfaction with providers, direct care workers, or Division staff. A grievance is not the same as a dispute regarding denial of a claim payment or claims reimbursement.

To file a grievance contact:

Family & Consumer Support Unit
602-542-6850 (phone)
1-866-229-5553 (toll free)

Provider Claim Disputes

A claim dispute is a dispute involving the payment of a claim, denial of a claim, imposition of a sanction, or reinsurance. A provider may file a claim dispute based on the denial of a claim, recoupment, or dissatisfaction with claims payment.

The claim dispute process should be used after informal attempts to resolve the matter have failed.

The provider must follow all applicable laws, policies, and contractual requirements regarding the filing of a claim dispute.

Claim disputes must be filed in writing to:

DDD Office of Appeals
3443 N Central Ave, Suite 600
Phoenix, Arizona 85012
602-771-8163 or 1-855-888-3106

Appeals

An appeal is a request for the review of an action by an enrollee (member) or their authorized representative, such as a provider. An appeal can be filed for various reasons including the denial or limited authorization of a requested service; the

type or level of service; or the reduction, suspension or termination of a previously authorized service. An authorized representative acting on behalf of the member, with the member's written consent, may file an appeal or request a State Fair Hearing on behalf of the member.

CHAPTER 12 - BILLING AND ENCOUNTER SUBMISSION

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [AHCCCS](#); [Billing Information](#)

All providers who participate in the AHCCCS program must be registered with AHCCCS and be assigned a Provider of Service (POS) number (i.e., a six-digit registration number). Additionally, providers are required to register their National Provider Identifier (NPI) with AHCCCS. The provider must notify the Division Contract Management Unit within two (2) business days in the event their AHCCCS POS number changes. Your current Federal Tax ID number associated with your Division contract and NPI are required on claims. Information about AHCCCS requirements and use of an NPI can be found on the AHCCCS website.

Acceptable Claim Forms

For HCBS services, the Division requires Qualified Vendors to submit claims using the Division's FOCUS system (the Division's automated service authorization and payment processing system. Please refer to the Division's Billing Manual for more information.

For Acute Care Services delivered by the health plan to AIHP members, there are three different types of claim forms that must be used.

- CMS-1500 Form: For claims for professional services.
- UB-04 Form: For claims for hospital in-patient and out-patient services, dialysis, hospice, and skilled nursing facility services.
- ADA Claim Form: For claims for dental services.

A claim form cannot exceed 99 lines. The Division complies with all AHCCCS billing and payment requirements when processing claims. Valid and approved AHCCCS Health Care Procedure Coding System (HCPCS) codes must be used on claims submitted to the Division.

CHAPTER 13 - UTILIZATION MANAGEMENT

INITIAL IMPLEMENTATION DATE: March 29, 2013

Utilization management is a function of prior authorization and concurrent review. The Division's Acute Care Health Plans have developed their own policies and procedures for both prior authorization and concurrent review standards. Providers are expected to follow the Division's policies and procedures.

For Division members enrolled with AIHP, prior authorization is required before rendering any service.

Prior authorization spreadsheet for Home and Community Based Services can be found on the Division's website. (<https://www.azdes.gov/main.aspx?menu=96&id=2470>
Service Approval Matrix (Prior Authorization))

CHAPTER 14 - REIMBURSEMENT

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [42 CFR 438.106](#); [A.R.S. §36-2931](#); [A.A.C R9-22-711](#)

Pursuant to 42 CFR 438.106, Division ALTCS members (as defined by ARS §36-2931) are not subject to payment liability to providers who provide covered services. Further, Division ALTCS members are not required to make a copayment for any covered services pursuant to AAC R9-22-711.

The Division's Acute Care Health Plans have a mechanism for reimbursing members for their out-of-pocket expenses for covered services. Providers are responsible for billing any private insurance and/or Medicare before submitting a claim to the Division or one of its Health Plans. When a member does have private insurance or Medicare an Explanation of Benefits (EOB) must be attached to the claim submitted to the Division.

CHAPTER 15 - COST SHARING RESPONSIBILITY

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [42 CFR 438.106](#); [A.R.S § 36-2931](#); [A.A.C R9-22-711](#)

Pursuant to 42 CFR 438.106, Division ALTCS members (as defined by A.R.S §36-2931) are not subject to payment liability to providers who provided covered services. Further, Division ALTCS members are not required to make copayment for any covered service pursuant to A.A.C R9-22-711.

CHAPTER 16 – EXPLANATION OF REMITTANCE ADVICE

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [Billing Information](#)

See Billing Information on the Division's website.

CHAPTER 17 – PRIOR AUTHORIZATION REQUIREMENTS

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [AHCCCS](#) – Medical Policy Manual; [Mercy Care Plan](#); [Care 1st](#); [Arizona Physicians, IPA](#); [Prior Authorization for HCBS](#)

To receive prior authorization for acute care services for a Division member enrolled with an acute care health plan, providers should contact the Prior Authorization Department of the member's acute care Health Plan.

To receive prior authorization for acute care services for a Division member enrolled with American Indian Health Program (AIHP), providers should contact the Division's Health Care Services Prior Authorization Unit at the contact information below.

The Division adheres to the prior authorization guidelines and timelines available in the AHCCCS Medical Policy Manual. Standard authorization requests will be processed within 14 calendar days of physician's order. Expedited authorization requests must be noted as such and will be processed within three working days of physician's order.

Health Care Services/Prior Authorization Unit
3443 North Central Avenue, Suite 600
Site Code 795M
Phoenix, Arizona 85005
(602) 771-8080 phone
(800) 624-4964 toll-free
(602) 238-9294 fax

Prior authorization for Home and Community Based Services can be found on the Division's website.

CHAPTER 18 - CLAIMS MEDICAL REVIEW

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [Mercy Care Plan](#); [Care 1st](#); [Arizona Physicians, IPA](#)

The Division reserves the right to review any and all claims for eligible members who were provided covered services for which a provider is requesting or has requested payment from the Division. The Division's acute care health plans may employ their own claims medical review processes. Providers may refer to the appropriate acute care health plan's website for further information.

CHAPTER 19 – CONCURRENT REVIEW

INITIAL IMPLEMENTATION DATE: March 29, 2013

The Division has a team of medical professionals who perform concurrent and retrospective review for members enrolled with American Indian Health Program (AIHP) who experienced a stay in an inpatient or skilled nursing setting. The Division's acute care health plans perform their own utilization review and concurrent review for Division members enrolled with their health plan who experienced a stay in an inpatient or skilled nursing setting.

CHAPTER 20 - FRAUD AND ABUSE

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [42 CFR 455.2](#); [A.R.S. §§ 46-451](#) and [13-3623](#)

The Division is committed to the prevention and detection of fraud and abuse. As providers, you are responsible to administer internal controls to guard against fraud and abuse.

Abuse of the Program

Abuse is defined by Federal law ([42 CFR 455.2](#)) as provider practices that are inconsistent with sound fiscal, business, or medical practices, and result in an unnecessary cost to the Medicaid program, or in reimbursement for services that are not medically necessary or fail to meet professionally recognized standards for health care. It also includes recipient practices that result in unnecessary cost to the Medicaid program.

Abuse of a Member

Abuse of a member, as defined by Arizona law ([A.R.S. §§ 46-451](#) and [13-3623](#)), means any intentional, knowing or reckless infliction of physical harm, injury caused by negligent acts or omissions, unreasonable confinement, emotional or sexual abuse, or sexual assault.

Definition of Fraud

Fraud is defined by Federal law ([42 CFR 455.2](#)) as an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or some other person. It includes any act that constitutes fraud under applicable Federal or State law.

Examples of Fraud

Falsifying Claims/Encounters: Alteration of a claim; incorrect coding; double-billing; or false data submitted.

Falsifying Services: Billing for services/supplies not provided; misrepresentation of services/supplies; or substitution of services.

Administrative/Financial: Kickbacks; falsifying credentials; fraudulent enrollment practices; fraudulent Third Party Liability (TPL) reporting; or fraudulent recoupment practices.

Member Issues (Fraud) Eligibility Determination Issues: Resource misrepresentation (transfer /hiding); Residency; or household composition.

The Division will:

- A. review all participating providers during the credentialing/certification process (including re-credentialing); and
- B. monitor providers for non-compliance with Division contracts, rules, policies and procedures, in addition to AHCCCS policies.

Prior Authorization includes verification of:

- A. member eligibility,
- B. medical necessity,
- C. appropriateness of service being authorized,
- D. the service being requested is a covered service, and
- E. an appropriate provider referral.

The Division's electronic claims processing application executes over 150 payment edits ensuring payment accuracy and guarding against fraud and abuse. Some of these edits include: member eligibility; covered services; prior authorization; appropriate services codes; dates of services; authorized units and units provided; duplicate claims; approved rates; and utilization.

The Division, with the support of the Department's Audit and Management Services Division, conducts post payment reviews. These reviews look retrospectively at a sample of paid claims to ensure provider internal controls are in place. These reviews include the review of provider files, such as timesheets, to ensure proper documentation.

Quality Management conducts regularly scheduled on-site reviews. Additional reviews may be conducted on an as needed basis.

If at any time during the above processes, an unusual incident is suspected or discovered, the matter is referred to the Department's Fraud Coordinator.

Reporting Procedures

When a provider discovers or becomes aware of an incident of potential/suspected fraud or abuse, the provider shall immediately report the incident to the Division.

Fraud and Abuse of the Program

To report suspected fraud or abuse of the program:

- A. Call the toll free DES/DDD Hotline at 877-822-5799
- B. Report the incident by completing the online referral form at:
<https://www.azdes.gov/forms.aspx?menu=96&form=7105>

Abuse of a Member

Providers shall comply with mandatory reporting requirements in accordance with A.R.S. §13-3620 for children under age 18, and A.R.S. §46-454 for adults, as outlined in Chapter 2000 of the Division's Policy and Procedure Manual.
(https://www.azdes.gov/uploadedFiles/Developmental_Disabilities/2000.pdf)

In addition, providers shall report to the Division all incidents of suspected abuse of a member in accordance with the policy and procedures detailed in Chapter 2100.
(https://www.azdes.gov/uploadedFiles/Developmental_Disabilities/2100.pdf)

CHAPTER 21 - FALSE CLAIMS ACT

INITIAL IMPLEMENTATION DATE: March 29, 2013

The Deficit Reduction Act of 2005 (DRA) was signed into law in early 2006. The DRA encourages states to have false claims legislation in place. The DRA also requires any entity, including providers, receiving annual Medicaid payments of \$5 million or more to provide written policies to all employees, contractors, and agents about the False Claims Act. Any state laws that pertain to civil or criminal penalties for making false claims and statements, and the whistleblower protection under such laws, including the role of such laws in preventing and detecting fraud, waste and abuse in federal health care programs, should also be included in these policies.

CHAPTER 22 - FORMULARY INFORMATION

INITIAL IMPLEMENTATION DATE: March 29, 2013

AHCCCS has developed a minimum required drug list and its contractors, including the Division and its subcontracted Health Plans are required to cover for members. Contractors can cover more drugs than are listed but not less. The Division has provided its formulary and links to its Health Plan's formularies at the link below.

Formulary information can be found on the Division's website:

<https://www.azdes.gov/main.aspx?menu=96&id=2662>

CHAPTER 23 - AHCCCS APPOINTMENTS AND STANDARDS

INITIAL IMPLEMENTATION DATE: March 29, 2013

For PCP appointments, for members, providers shall provide:

- A. Emergency appointments the same day or within twenty-four (24) hours of the member's phone call or other notification, or as medically appropriate
- B. Urgent care appointments within two (2) days
- C. Routine care appointments within twenty-one (21) days

For specialty provider appointments for members, providers shall provide:

- A. Emergency appointments within twenty-four (24) hours of referral
- B. Urgent care appointments within three (3) days of referral
- C. Routine care appointments within forty-five (45) days of referral

For behavioral health services for members, providers shall provide appointments as follows:

- A. Emergency appointments within twenty-four (24) hours of referral
- B. Routine appointments within thirty (30) days of referral

For dental appointments for members, providers shall be able to provide:

- A. Emergency appointments within twenty-four (24) hours
- B. Urgent appointments within three (3) days of request
- C. Routine care appointments within forty-five (45) days of request

For maternity care for members, providers shall provide initial prenatal care appointments for enrolled pregnant members as follows:

- A. First trimester within fourteen (14) days of request
- B. Second trimester within seven (7) days of request
- C. Third trimester within three (3) days of request
- D. High risk pregnancies within three (3) days of identification of high risk by the Division or maternity care provider, or immediately if an emergency exists.

For wait time in the office, ADES/DDD shall monitor and ensure that a member's waiting time for a scheduled appointment at the PCP's or specialist's office is no more than forty-five (45) minutes, except when the provider is unavailable due to an emergency.

For medically-necessary, non-emergent transportation shall be scheduled so that the member:

- A. arrives on time but no sooner than one hour before the appointment;
- B. is not picked up prior to the completion of the appointment;
- C. is not required to wait more than one hour after the conclusion of the appointment for transportation home.

CHAPTER 24 – AMERICAN WITH DISABILITIES ACT

INITIAL IMPLEMENTATION DATE: March 29, 2013

Title VI of the Civil Rights Act of 1964 prohibits discrimination on the basis of race, color, and national origin in programs receiving federal financial assistance. The Americans with Disabilities Act (ADA) prohibits discrimination against people with disabilities in employment, public services, public accommodations, and telecommunications. Providers contracted with the Division shall comply with the Americans with Disabilities Act (ADA) and Title VI of the Civil Rights Act of 1964.

CHAPTER 25 – ENROLLMENT VERIFICATION

INITIAL IMPLEMENTATION DATE: March 29, 2013

AHCCCS Online for Health Plans and Providers: All registered AHCCCS providers are eligible to create an account at: <https://azweb.statemedicaid.us/Home.asp>
This tool can be used to check eligibility/enrollment, enter claims, and check claim status.

Providers are expected to verify member's enrollment by requesting the member to present the acute care health plan identification card. If the member is unable to present the acute care health plan identification card, providers may verify enrollment by calling the Division's Health Care Services Member Services Unit at 602-771-8080.

CHAPTER 26 – CULTURAL COMPETENCY

INITIAL IMPLEMENTATION DATE: March 29, 2013

The Division promotes a culture of respect and dignity when working with individuals who have developmental disabilities and values a competent, diverse provider network capable of effectively addressing the needs and preferences of its culturally and linguistically diverse members. Cultural Competency refers to the ability of provider staff to acknowledge and understand the influence cultural history, life experiences, language differences; values and disability have on individuals and families.

Knowledge and use of “disability etiquette” are critical when establishing rapport and working with members with developmental disabilities. According to the National Center for Cultural Competence at Georgetown University, *“People first terminology is the standard that should govern all communication about this population (people with disabilities). Training and policy within health and mental health care organizations should require people first terminology such as individuals with developmental disabilities, a person with intellectual disabilities, and a patient with a physical disability or communication disorder.”*

The Division works with long term care contractors to provide services that are “culturally relevant and linguistically appropriate” to the population served. Requirements include an effective communication strategy when considering acceptance of a referral; reasonable steps to ensure meaningful access to Medicaid services for persons with limited English proficiency; written information available in the prevalent non-English languages in its particular service area; and interpreter services available at no charge for all non-English languages, not just those identified as prevalent.

For assistance in accessing non acute care interpreter services to support members who speak a language other than English or use sign language, please contact 602-542-0419.

CHAPTER 27 – PEER REVIEW AND INTER-RATER RELIABILITY

INITIAL IMPLEMENTATION DATE: March 29, 2013

For both acute and long term care services, the Division evaluates the necessity, quality, or utilization of care/service provided. For acute services, peer review is conducted by others from the same discipline, or with similar or essentially equal qualifications, who are not in direct economic competition with the health care professional under review. For long term care services, inter-rater reliability is conducted by Support Coordinators. The peer review process evaluates the consistency with which individuals involved in decision making apply standardized criteria in accordance with adopted practice guidelines.

CHAPTER 28 - MEMBER RIGHTS

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [42 CFR 438.100](#); [A.R.S § 36-551.01](#); [Division's Policy Manual: Chapter 1500](#)

All members have the right to be treated with dignity and respect. The Division is concerned with protecting the rights of all individuals who are receiving supports and services operated by, supervised or financially supported by the Division. The provider must ensure all employees are familiar with the information in the references listed above.

CHAPTER 29 - ADVISING OR ADVOCATING ON BEHALF OF A CONSUMER

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [42 CFR 438.102](#)

Pursuant to 42 CFR 438.102, the Division may not prohibit, or otherwise restrict, a provider acting within the lawful scope of practice, from advising or advocating on behalf of a consumer who is authorized to receive services from the provider for the following:

- A. The member's health status, medical care, or treatment options including any alternative treatment that may be self-administered.
- B. Any information the member needs in order to decide among all relevant treatment options.
- C. The risks, benefits, and consequences of treatment or no treatment.
- D. The member's right to participate in decisions regarding his or her health care, including the right to refuse treatment, and to express preferences about future treatment decisions.

CHAPTER 30 – CLINICAL PRACTICE GUIDELINES

INITIAL IMPLEMENTATION DATE: March 29, 2013

The Division has developed guidelines for its providers, members, and staff, to utilize. These guidelines are reviewed at least annually and are used when determining medical necessity. These guidelines may be obtained by contacting the Division's Prior Authorization Unit at 602-771-8080.

CHAPTER 31 - CHANGE OF CONTRACTOR

INITIAL IMPLEMENTATION DATE: March 29, 2013

REFERENCES: [A.R.S. § 36-2944](#)

Pursuant to Arizona Revised Statute, the Department of Economic Security provides services either directly or through subcontract to members who have a developmental disability. The Division is the only AHCCCS program contractor for members who have a developmental disability.

During annual enrollment Division members have the opportunity to change Acute Care Health Plans, subject to the availability of other contracted Acute Care Health Plans in their area. Members must notify the Division's Member Services Unit of their wish to change Acute Care Health Plans during the annual enrollment choice period. If the member does not participate in annual enrollment choice, and their eligibility is maintained, members will remain with their current Acute Care Health Plan.

The Division reserves the right to conduct an open enrollment, if deemed necessary, by Division Administration. Members must notify the Division if they wish to change contractors during open enrollment.

Members may have extenuating circumstances that necessitate changing contractors outside of the member's annual enrollment choice. AHCCCS Policy 402 documents and delineates the rights, obligations and responsibilities of:

- A. the member,
- B. the member's current health plan,
- C. the requested health plan, and
- D. the AHCCCS Administration.

This includes facilitating continuity of care, quality of care, efficient and effective program operations, and in responding to administrative issues regarding member notification and errors in assignment.